No. -1-4-41 5-17-39 X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31695

FILED OCT 7 1943

Registration District No. 1288

Primary Registration District No. 2000

Registrar's No. 791

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1918 East Avenue, Springfield, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Life time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 039
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1918 East Avenue.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rufus Albert Thompson

3. (b) If veteran, name war No

3. (c) Social Security No. Unk.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Nettie Thompson

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Sept. (Month) 5th (Day) 1873 (Year)

8. AGE: Years .70 Months -- Days 21 If less than one day hr. min.

9. Birthplace Webster County (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Retired Frisco Employee

11. Industry or business

FATHER
12. Name James Thompson
13. Birthplace Tenn. Unk. (City, town or county) Tenn! (State or foreign country)

MOTHER
14. Maiden name Rebecca King.
15. Birthplace Webster County, Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant W.R. Brittain,
(b) Address 1544 East Commercial Spfd. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28,43 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director W.R. Brown
(b) Address 629 W. Walnut, Springfield, Mo.

19. (a) 9-28-43 (Date received local registrar) (b) O.T. W.S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1943 hour 10.00 minute -- A. M.

21. I hereby certify that I attended the deceased from from 30 1943 to Sept. 26 1943
that I last saw him alive on Sept 18 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis (Duration 2 mos)

Due to General debility

Due to Gen Nervous Condition

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations No

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature J F Flaherty (M. D. or other)
Address Springfield Date signed 9/29/43

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Clarence D. McGahan

Licensed Embalmer No. 2891

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ULT

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 791

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rufus Albert Thompson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased Sept (Month) 5 (Day) — (Year)
8. AGE: Years 75 Months — Days — If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 24 year 1943 hour [illegible] minute [illegible] M.
21. I hereby certify that I attended the deceased from [illegible], 19..; that I last saw h... alive on [illegible], 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death, Paralysis Agitans	
Due to general senility	
Due to	
Other conditions (Include pregnancy within 3 months of death) 87c	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. F. Freeman (M. D. or other)
Address Springfield Mo Date signed 9/28/43

SUPPLEMENTARY

31695